

- ☐ Initiate Waiver service
- ☐ Service Modification (add a service)
- ☐ Increase or decrease units/hours of service
- ☐ Provider Modification (requires 2 ISARs)
- ☐ Procedure Code Modification (requires 2 ISARs)
- ☐ End a service

## MR Waiver 60-Day Assessment Individual Service Authorization Request

CSB \_\_\_\_\_

CSB provider # \_\_\_\_\_

Provider Name Name: _____	Start: _____	Provider Number End: _____
Last, First MI Date Date		

Medicaid Number: \_\_\_\_\_

CHECK SERVICE TO BE PROVIDED	WEEKLY / MONTHLY HOURS / UNITS	OMR USE ONLY
<input type="checkbox"/> H2014 Supported Living / In-Home—Total # of persons with disabilities in residence: _____	<div style="display: flex; justify-content: space-between;"> <div>Weekly Hours</div> <div>x 4.6 =</div> <div>Monthly Total 1</div> </div>	
<input type="checkbox"/> 97535 Congregate (please specify below)—Total # of persons with disabilities in residence: _____ <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Group Home  <input type="checkbox"/> Adult Foster Care Home  <input type="checkbox"/> Sponsored Residential           </div> <div> <input type="checkbox"/> Group Home for Children  <input type="checkbox"/> Other: _____           </div> </div>	<div style="display: flex; justify-content: space-between;"> <div>Weekly Hours</div> <div>x 4.3 =</div> <div>Monthly Total 1</div> </div>	
<input type="checkbox"/> T1019 Personal Assistance—Total # of persons with disabilities in residence: _____	<div style="display: flex; justify-content: space-between;"> <div>Weekly Hours</div> <div>x 4.6 =</div> <div>Monthly Total 1</div> </div>	
<input type="checkbox"/> 97537 DS Reg. Int. Center-Based or Non-Center-Based <input type="checkbox"/> 97537 U1 DS High Int. Center-Based or Non-Center-Based <input type="checkbox"/> H2025 PREVOC Reg. Intensity <input type="checkbox"/> H2025 U1 PREVOC High Intensity <input type="checkbox"/> Check this box to verify meeting at least 1 of the criteria if requesting high intensity service above.	<div style="display: flex; justify-content: space-between;"> <div>Weekly Units</div> <div>x 4.6 =</div> <div>Monthly Total 1</div> </div>	
Enter <b>Periodic Support hours/units</b> per month if needed – RS, PA, DS & PV only. <b>Do not include in hours per day below.</b>		<div style="display: flex; justify-content: space-between;"> <div></div> <div>Monthly Total</div> </div>
Enter <b>TOTAL</b> of Periodic Support hours/units + regular hours/units per month.		<div style="display: flex; justify-content: space-between;"> <div></div> <div>Monthly Total 2</div> </div>
<input type="checkbox"/> H2023 Supported Employment, Individual Placement	<div style="display: flex; justify-content: space-between;"> <div>Weekly Hours</div> <div>x 4.6 =</div> <div>Monthly Total</div> </div>	
<input type="checkbox"/> H2024 Supported Employment, Enclave/Work Crew	<div style="display: flex; justify-content: space-between;"> <div>Weekly Units</div> <div>x 4.6 =</div> <div>Monthly Total</div> </div>	

**While providing the agreed-upon supports and services, a 60-day assessment must be used to 1) evaluate the individual's needs and interests in the service environment and community settings and 2) develop an annual service plan.**

**Why is this assessment period needed for this individual?**

**Check the allowable activities that are included in the ISP. Indicate the *total* number of hours per day for each section below:**

Assessment of and assistance with:	Sun	Mon	Tues	Wed	Thur	Fri	Sat
<input type="checkbox"/> participation in a variety of settings and activities <input type="checkbox"/> all life skill areas related to the service, including identification of personal preferences <input type="checkbox"/> health and safety issues							
<input type="checkbox"/> needs for nighttime specialized supervision (Residential only)— <i>Provide explanation and what staff will do.</i>							
<b>Travel with the individual to and from DS/SE/PREVOC program:</b> (record if billing for this time; can be included up to 25% of the total time; to bill for a 3-unit day, a minimum of 7 hrs of other allowable activities is required; does not include training related travel in scheduled activities)							

**ATTACH ADDITIONAL PAGES IF FURTHER EXPLANATION IS NEEDED.**

*We, the undersigned, assure that the assessment ISP will be followed by the development and implementation of an annual ISP (approved by the individual) by the end of the 60-day period.*

Name of Provider Agency Representative (print)	Signature	Date
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*In addition to the assurance above, I agree that the assessment plan of services is appropriate to the identified needs of this individual. This service plan has been approved by the individual and included in the CSP maintained in the Case Manager's record.*

CSB Rep/Case Manager (print)	Signature	Phone No.	Fax No.	Date
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